		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037507

Facility Name: Sherman West Court

Address: 1950 Larkin Avenue (Number) Elgin (City) 60123-5843 (Zip Code)

County: Kane

Telephone Number: (847) 742-7070 **Fax #** (847) 742-7248

IDPA ID Number: 363725580001

Date of Initial License for Current Owners: 02/18/91

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 05/01/2002 to 04/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	112	Skilled (SNF)	112	40,880	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	8	Sheltered Care (SC)	8	2,920	5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,566	16,166	9,769	30,501	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		3,311		3,311	12
13	DD 16 OR LESS					13
14	TOTALS	4,566	19,477	9,769	33,812	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.20%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/18/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/18/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 9,769

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 04/30/2003 Fiscal Year: 04/30/2003

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	254,875	11,155	3,990	270,020		270,020		270,020			1
2	Food Purchase		157,510		157,510		157,510	(4,330)	153,180			2
3	Housekeeping	109,492		17,358	126,850		126,850		126,850			3
4	Laundry	33,102	10,515		43,617		43,617		43,617			4
5	Heat and Other Utilities			141,069	141,069		141,069		141,069			5
6	Maintenance	68,870	3,232	51,644	123,746		123,746		123,746			6
7	Other (specify):*											7
8	**TOTAL General Services**	466,339	182,412	214,061	862,812		862,812	(4,330)	858,482			8
	B. Health Care and Programs											
9	Medical Director			42,300	42,300		42,300		42,300			9
10	Nursing and Medical Records	2,177,146	111,952	5,180	2,294,278		2,294,278		2,294,278			10
10a	Therapy	319,093	1,731		320,824		320,824		320,824			10a
11	Activities	62,448	2,850	2,364	67,662		67,662	1,335	68,997			11
12	Social Services	28,179			28,179		28,179		28,179			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,586,866	116,533	49,844	2,753,243		2,753,243	1,335	2,754,578			16
	C. General Administration											
17	Administrative	78,208		229,485	307,693		307,693	(229,485)	78,208			17
18	Directors Fees											18
19	Professional Services			46,535	46,535		46,535	(3,955)	42,580			19
20	Dues, Fees, Subscriptions & Promotions			25,875	25,875		25,875		25,875			20
21	Clerical & General Office Expenses	303,203	7,707	82,018	392,928		392,928	213,066	605,994			21
22	Employee Benefits & Payroll Taxes			728,761	728,761		728,761		728,761			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,188	21,188		21,188		21,188			24
25	Other Admin. Staff Transportation			561	561		561		561			25
26	Insurance-Prop.Liab.Malpractice			85,333	85,333		85,333		85,333			26
27	Other (specify):*											27
28	**TOTAL General Administration**	381,411	7,707	1,219,756	1,608,874		1,608,874	(20,374)	1,588,500			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,434,616	306,652	1,483,661	5,224,929		5,224,929	(23,369)	5,201,560			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Sherman West Court #0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			222,745	222,745		222,745	13,488	236,233			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			233,285	233,285		233,285	(7,635)	225,650			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,631	9,631		9,631		9,631			35
36	Other (specify):*											36
37	**TOTAL Ownership**			465,661	465,661		465,661	5,853	471,514			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			4,229	4,229		4,229		4,229			38
39	Ancillary Service Centers		614,194		614,194		614,194		614,194			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):* Nonallowable Costs			119,844	119,844		119,844	(119,844)				43
44	**TOTAL Special Cost Centers**		614,194	185,393	799,587		799,587	(119,844)	679,743			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,434,616	920,846	2,134,715	6,490,177		6,490,177	(137,360)	6,352,817			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,356)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,640)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16	30		9
10	Interest and Other Investment Income	(7,635)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,528)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(77,343)	43		24
25	Fund Raising, Advertising and Promotional	(15,357)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(29,116)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (140,959)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	3,599		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 3,599		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (137,360)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
IDPH Facility ID # 0037507
4/30/2003

Schedule 5A

Schedule VI.
Line 29, Other

Nonallowable Expenses	Amount	Reference
Printing and forms	(1,976)	43
Lab expense	(22,640)	43
Out of period legal fees	(3,955)	19
Miscellaneous income offset	(906)	4
Activity income offset	1,335	11
Vending income offset	(974)	2
Total	(29,116)	

See Accountants' Compilation Report

Sherman West Court

ID# 0037507

Report Period Beginning: 05/01/2002

Ending: 04/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 05/01/2002 **Ending:** 04/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,356)	0	0	0	0	0	0	0	0	0	0	(3,356)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,356)	0	0	0	0	0	0	0	0	0	0	(3,356)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(229,485)	0	0	0	0	0	0	0	0	0	(229,485)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(5,640)	219,612	0	0	0	0	0	0	0	0	0	213,972	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,640)	(9,873)	0	0	0	0	0	0	0	0	0	(15,513)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,996)	(9,873)	0	0	0	0	0	0	0	0	0	(18,869)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 05/01/2002 **Ending:** 04/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	16	13,472	0	0	0	0	0	0	0	0	0	13,488	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,635)	0	0	0	0	0	0	0	0	0	0	(7,635)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,619)	13,472	0	0	0	0	0	0	0	0	0	5,853	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(95,228)	0	0	0	0	0	0	0	0	0	0	(95,228)	43
44	**TOTAL Special Cost Centers**	(95,228)	0	0	0	0	0	0	0	0	0	0	(95,228)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(111,843)	3,599	0	0	0	0	0	0	0	0	0	(108,244)	45

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sherman Health Systems	100%			Sherman Hospital	Elgin	Hospital
				Sherman Home		Home Health
				Care Partners	Elgin	Agency
				Sherman Health		
				Systems	Elgin	Management Co.
See Schedule 6A for Board of Directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 229,485	Sherman Health Systems	100.00%	$	$ (229,485)	1
2	V	21	Administrative Expenses		Sherman Health Systems	100.00%	219,612	219,612	2
3	V	30	Depreciation Expense		Sherman Health Systems	100.00%	13,472	13,472	3
4	V	10	Nursing Cost		Sherman Hospital				4
5	V	21	Office Supplies	960	Sherman Hospital		960		5
6	V	22	Fringe Benefits	120,201	Sherman Hospital		120,201		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 350,646			$ 354,245	$ * 3,599	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
Facility #0037507
04/30/2003

Medicaid Cost Report
Schedule 6A

Page 6: VII - Schedule A - Non-Profit required attachment: List of Board of Directors

Board Member	Directly Provided Services	Type of Service	Entity owned by Board Member doing Business with nursing home	Type of Business Conducted
Reverend Dr. Robert D. Linstrom	No	N/A	N/A	N/A
Richard S.Scheflow	No	N/A	N/A	N/A
Earl W. Lamp	No	N/A	N/A	N/A
Al Pagorski	No	N/A	N/A	N/A
Toni Geister	No	N/A	N/A	N/A
Richard Floyd	No	N/A	N/A	N/A
Kyung W. Koo, M.D.	Yes	Medicare Medical Director	N/A	N/A
Elaine Hastings	No	N/A	N/A	N/A
D. Ray Wilson	No	N/A	N/A	N/A

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3				N/A							3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 4/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sherman Health Systems
Street Address: 1019 East Chicago Street
City / State / Zip Code: Elgin, IL 60120-6822
Phone Number: (847) 608-6114
Fax Number: (847) 608-6117

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Administrative Expenses	Accumulated Costs	203,949,986	3	$ 7,004,276	$	6,394,652	$ 219,612	1
2	30	Depreciation Expense	Accumulated Costs	203,949,986	3	429,667		6,394,652	13,472	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,433,943	$		$ 233,084	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Illinois Health Facilities		x	Refinance construction bond	$24,326.00	10/15/97	$ 4,736,121	$ 4,292,833	8/2027	Various	$ 233,285	1
2	Authority											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$24,326.00		$ 4,736,121	$ 4,292,833			$ 233,285	9
	B. Non-Facility Related*											
10	Interest Income Offset										(7,635)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,635)	14
15	TOTALS (line 9+line14)						$ 4,736,121	$ 4,292,833			$ 225,650	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ None** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

No real estate taxes to be paid in 2002 or 2003 due to real estate tax exempt status being granted.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sherman West Court COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0037507

CONTACT PERSON REGARDING THIS REPORT Ms. Anne Huang

TELEPHONE (847) 742-7070 FAX #: (847) 742-7248

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,260 B. General Construction Type: Exterior Brick Frame Wood/Masonry Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	115,500	1991	$ 504,179	1
2					2
3	TOTALS	115,500		$ 504,179	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1991	1991	$ 2,486,860	$ 62,171	40	$ 62,171	$	$ 759,010	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1991	99,031		5			99,031	9
10	Building Improvements			1991	219,089		10			219,089	10
11	Building Improvements			1991	205,843	13,723	15	13,723		167,534	11
12	Building Improvements			1991	826,676	41,334	20	41,334		504,618	12
13	Building Improvements			1991	91,155	3,646	25	3,646		44,513	13
14	Building Improvements			1991	21,960		10			21,960	14
15	Building Improvements			1991	3,398	227	15	227		2,606	15
16	Building Improvements			1992	22,980	1,149	10	1,149		22,980	16
17	Building Improvements			1992	2,000	183	15	133	(50)	1,399	17
18	Building Improvements			1993	962		5			962	18
19	Building Improvements			1993	13,219	1,322	10	1,322		12,558	19
20	Building Improvements			1993	3,750	250	15	250		2,375	20
21	Building Improvements			1993	14,525		20	726	726	6,898	21
22	Building Improvements			1994	6,951	348	20	348		2,955	22
23	Carpet Tiles			1995	1,500	150	10	150		1,125	23
24	Sliding Doors			1996	3,345	334	10	334		2,508	24
25	Resurface Parking Lot			1996	4,800		5			4,800	25
26	Carpeting			1997	3,930		5			3,930	26
27	Carpet/tile Base			1997	12,580		5			12,580	27
28	Kickplates			1997	4,165	417	5	417		4,165	28
29	Carpet Living Room			1998	4,340	433	10	433		1,950	29
30	Cement Board & Ceramic Tile			1999	4,475	448	10	448		2,016	30
31	Wallpaper			1999	1,819	363	5	363		1,635	31
32	Landscaping			1999	893	179	5	179		805	32
33	Construction contract for new entrance & nursing statior			1999	938,914	23,473	40	23,473		91,451	33
34	Kitchen Wall Boards			2000	1,365	273	5	273		955	34
35	Parking Lot Improvements			2000	52,250	1,742	30	1,742		5,226	35
36	Purchasing Department Ceiling Light Fixtures			2000	1,967	197	10	197		591	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2002	$ 19,785	$ 3,957	5	$ 3,957	$	$ 4,123	37
38	Wallpaper	2002	19,893	3,979	5	3,979		4,145	38
39	Roofing	2001	1,400	140	10	140		210	39
40	Door	2001	1,125	75	15	75		113	40
41	Carpeting	2003	5,732	573	5	573		573	41
42	Carpeting	2003	1,855	186	5	186		186	42
43	Wiring for therapy rooms	2003	4,431	222	10	222		222	43
44	HVAC upgrade and testing	2003	52,902	1,764	15	1,764		1,764	44
45	Fire sprinklers	2003	12,149	304	20	304		304	45
46	HVAC upgrade and testing	2003	51,875	5,188	10	5,188		5,188	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,225,889	$ 168,750		$ 169,426	$ 676	$ 2,019,053	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 577,715	$ 44,811	$ 44,811	$	5-20	$ 271,113	71
72	Current Year Purchases	50,018	8,524	8,524		5-15	8,524	72
73	Fully Depreciated Assets	562,695				5	562,695	73
74	Allocated from Sherman Health Systems			13,472	13,472			74
75	TOTALS	$ 1,190,428	$ 53,335	$ 66,807	$ 13,472		$ 842,332	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,920,496	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 222,085	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 236,233	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,148	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,861,385	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 9,631 Description: Copy Machines: $9,631
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 1	2226 hrs	$ 48,923		$	$	2,226	$ 48,923	1
2	Licensed Speech and Language Development Therapist	L10A, C 1	1456 hrs	36,897				1,456	36,897	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C 1 & 2	4897 hrs	137,276			1,731	4,897	139,007	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C 2	# of prescrpts				573,629		573,629	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Specialized Beds Other (specify): Oxygen	L39, C 2 L39, C 2					15,916 24,649		24,649	13
14	TOTAL			$ 223,096		$	$ 615,925	8,579	$ 823,105	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 04/30/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 632,979	$ 632,979	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 156,784)	1,163,272	1,163,272	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,134	70,134	6
7	Other Prepaid Expenses	3,160	3,160	7
8	Accounts Receivable (owners or related parties)	86,437	86,437	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,955,982	$ 1,955,982	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	504,179	504,179	13
14	Buildings, at Historical Cost	5,212,124	5,225,889	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,191,298	1,190,428	16
17	Accumulated Depreciation (book methods)	(2,858,139)	(2,861,385)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Bond Issue Cost	66,660	66,660	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,116,122	$ 4,125,771	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,072,104	$ 6,081,753	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 148,826	$ 148,826	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	84,750	84,750	29
30	Accrued Salaries Payable	284,366	284,366	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	56,462	56,462	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	2,674,266	2,674,266	36
37	Deferred Income, Accrued Expenses	257,540	257,540	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,506,210	$ 3,506,210	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,208,083	4,208,083	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,208,083	$ 4,208,083	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,714,293	$ 7,714,293	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,642,189)	$ (1,632,540)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,072,104	$ 6,081,753	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,710,420)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,710,420)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	68,231	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 68,231	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,642,189)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,005,654	1
2	Discounts and Allowances for all Levels	(1,570,959)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,434,695	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,018,804	6
7	Oxygen	75,003	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,093,807	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,337	13
14	Non-Patient Meals	3,356	14
15	Telephone, Television and Radio	5,640	15
16	Rental of Facility Space		16
17	Sale of Drugs	799,678	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,436	19
20	Radiology and X-Ray		20
21	Other Medical Services	189,129	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,016,576	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,635	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,635	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous, Vending, & Activities Income	545	28
28a	Donation Income	5,150	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,695	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,558,408	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	862,812	31
32	Health Care	2,753,243	32
33	General Administration	1,608,874	33
	B. Capital Expense		
34	Ownership	465,661	34
	C. Ancillary Expense		
35	Special Cost Centers	738,267	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,490,177	40
41	**Income before Income Taxes (line 30 minus line 40)****	68,231	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 68,231	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,429	3,705	$ 142,507	$ 38.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,395	36,882	997,103	27.03	3
4	Licensed Practical Nurses	6,558	6,929	144,381	20.84	4
5	Nurse Aides & Orderlies	57,116	61,750	809,674	13.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,983	8,579	223,096	26.00	7
8	Rehab/Therapy Aides	5,490	6,036	95,997	15.90	8
9	Activity Director	1,995	2,190	37,612	17.17	9
10	Activity Assistants	2,720	2,915	24,836	8.52	10
11	Social Service Workers	1,431	1,503	28,179	18.75	11
12	Dietician	1,174	1,178	23,091	19.60	12
13	Food Service Supervisor	3,178	3,293	65,654	19.94	13
14	Head Cook	5,960	6,325	68,983	10.91	14
15	Cook Helpers/Assistants					15
16	Dishwashers	11,637	12,331	97,147	7.88	16
17	Maintenance Workers	3,977	4,324	68,870	15.93	17
18	Housekeepers	11,944	12,554	109,492	8.72	18
19	Laundry	3,769	4,205	33,102	7.87	19
20	Administrator	1,902	2,086	78,208	37.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,942	2,086	59,050	28.31	23
24	Clerical	15,803	17,028	244,153	14.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,894	2,085	26,225	12.58	31
32	Other Health Ca See Sch. 20A	3,312	3,554	57,256	16.11	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	186,609	201,538	$ 3,434,616 *	$ 17.04	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	42,300	L 9, C 3	36
37	Medical Records Consultant	16	1,236	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,440	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	940	L 11, C 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	84	$ 45,916		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Sherman West Court
IDPH Facility ID # 0037507
4/30/2003

Schedule 20A

Schedule XVIII
Line 32, Other

Description	Hours Worked	Hours Paid	Salaries/ Wages	Average
MDS Coordinator	1,396	1,444	35,564	24.63
Nursing Secretary	1,916	2,110	21,692	10.28
Total	3,312	3,554	57,256	

See Accountants' Compilation Report

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anne Huang	Administrator	0%	$ 78,208
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,208

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 229,485
TOTAL (agree to Schedule V, line 17, col. 3)	$ 229,485
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Scheflow & Rydell	Legal	$ 3,955
Altschuler, Melvoin & Glasser LLP	Accounting	13,008
American Express Tax and Business Services Inc.	Accounting	4,034
Accu-Med Services	Computer Processing	9,403
Comprehensive Therapeutics	Alzheimers Consulting	12,235
Ernst & Young, LLP	Accounting	1,500
Coleman Land Co.	Appraisal	1,400
Nebraska INS	INS Fees	1,000
See Schedule 21A		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 46,535

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,061
Unemployment Compensation Insurance	21,295
FICA Taxes	262,405
Employee Health Insurance	148,375
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contributions	46,367
Employee Recognition	3,824
Employee Benefits PTO	96,744
Other Employee Insurance	16,204
Other Employee Benefits	16,486
TOTAL (agree to Schedule V, line 22, col.8)	$ 728,761

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,489
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network	4,137
Miscellaneous Dues & Subscriptions	325
Accreditation Fee	6,292
Miscellaneous License, Permits	4,632
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,875

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	671
Seminar Expense	20,517
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,188

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
Provider #: 0037507
05/01/2002 to 04/30/2003

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	46,535
Less: Out of period legal fees	(3,955)
Total (agree to Schedule V, line 19, column 8)	42,580

See Accountants' Compilation Report

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2002 Ending: 04/30/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $4,137**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **27,383** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **61,320**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **None** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **3,356**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Sherman West Court** **01:16 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-137,360	equal to	-137,360	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	225,650	equal to	225,650	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	236,233	equal to	236,233	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	9,631	equal to	9,631	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	223,096	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	224,827	equal to	320,824	-95,997	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	615,925	equal to	615,925	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	862,812	equal to	862,812	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,753,243	equal to	2,753,243	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,608,874	equal to	1,608,874	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	465,661	equal to	465,661	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	738,267	equal to	738,267	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	61,320	equal to	61,320	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,119,890	equal to	2,177,146	-57,256	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	223,096	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	62,448	equal to	62,448	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	28,179	equal to	28,179	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	254,875	equal to	254,875	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	68,870	equal to	68,870	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	109,492	equal to	109,492	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	33,102	equal to	33,102	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	78,208	equal to	78,208	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	303,203	equal to	303,203	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,434,616	equal to	3,434,616	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	3,990	-3,990	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	42,300	< or = to	42,300	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,676	< or = to	5,180	-2,504	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	940	< or = to	2,364	-1,424	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	78,208	equal to	78,208	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	229,485	equal to	229,485	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	46,535	equal to	46,535	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	728,761	equal to	728,761	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	25,875	equal to	25,875	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	21,188	equal to	21,188	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	61,320	equal to	61,320	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	None	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	None	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	9,769	equal to	9,769	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	3,599	equal to	3,599	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	4,292,833	equal to	4,292,833	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	504,179	equal to	504,179	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	5,225,889	equal to	5,225,889	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,190,428	equal to	1,190,428	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,861,385	equal to	2,861,385	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,642,189	equal to	-1,642,189	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	68,231	equal to	68,231	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	6,072,104	equal to	6,072,104	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK**						
	TO THE COST REPORT!!		11/04/05		01:16:25 PM		
HSA Number	?	Name	Sherman West Court				
Cost report period	From:	05/01/2002	To:	04/30/2003	Base Number	328	
If this is an ICF/DD 16 facility, enter a 1 in cell C		N					
Licensed bed days:	43,800	Occupancy:	33,812	Pct. of occupancy:	77.20%		
Illinois Public Aid Support Rate		$					
Genl Services Salary/Wage:	466,339	Col 1, Line 8 ---Audit Adj:					
Genl Admin Salary/Wage	381,411	Col 1, Line 28 ---Audit Adj					
Total Salary Wage	3,434,616	Col 1, Line 44 ---Audit Adj					
Employee Benefits	728,761	Col 8, Line 22 ---Audit Adj					
Total General Services:	858,482	Col 8, Line 8 ---Audit Adj:					
Total General Admin	1,588,500	Col 8, Line 28 ---Audit Adj					

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amou out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amou by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$466,339
Divided by Total Wages (Column 1, Line 44	$3,434,616
General service wages as percent of total wages	13.5776%
Employee Benefits (Column 10, Line 22	$728,761
Allocation of Employee Benefits to General Services Costs	$98,948
Plus Total General Services (Column 10, Line 8	$858,482
New Total General Services Cost	$957,430

B. General Administration

1 Determine the proportion of General Administratio wages to total wages.

2 Multiply the total lump sum fringe amount by th proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your tota General Administration expenses

4 Subtract the total lump sum fringe amount from you General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$381,411
Divided by Total Wages (Column 1, Line 45	$3,434,616
General administration wages as a percent of total wages	11.1049%
Employee Benefits (Column 10, Line 22	$728,761
Allocation of Emplayee Benefits to General Admin. Cost	$80,928
Plus Total General Administration (Column 10, Line 2	$1,588,500
Minus Total Fringe (Column 10, Line 22	$728,761
New Total General Administration Cos	$940,667

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflatior fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To selec the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select th inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	9	divided by 2 =	4.5
Beginning Day + Ending Day	31	divided by 60.8 =	0.509868421
Beginning Year + Ending Year =	205	multiplied by 6 =	1230
Sum of the three lines			1235.009868
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			328

B. Select the Appropriate Inflation Multiplier

Refer to Table I, inflation Multipliers, and find th multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$957,430	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$957,430

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$940,667	
General Administration Multiplier (Step II-E	1	
Updated General Services Cost		$940,667
3 Total Updated Support Costs (1 + 2		$1,898,097

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO	$52.55

A. If the occupancy (Cost Report, Page 2, Schedule III-C) i equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patien days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$1,898,097
Total Patient Days (Cost Report	33,812
Support Costs per Dien	$56.14

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patier days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	43,800
Multiplied by	0.93
	40,734
Minus total Patient Day	33,812
	6,922
One-third of difference	2,307
Plus Total Patient Day	33,812
Adjusted Occupancy	36,119
Total Support Costs (Step II, C, 3, above	$1,898,097
Divided by Adjusted Occupany	36119
Support Costs Per Dien	$52.55

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75t percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to c greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to o greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$52.55
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Plus Support Costs Per Dier	$52.55
Support Rate if costs are between 35th and 75th percentile	#N/A

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$52.55
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Compare one-half the difference to the profit ceiling for your HSA in Table II and	#N/A
Enter the Lower of the Two Amounts	#N/A
Plus Support Costs Per Dier	$52.55
Support Rate if support costs less than 35th percentile	#N/A

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc **#N/A**

75th Percentile is	#N/A
35th Percentile is	#N/A

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/04/05 01:16:25 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Sherman West Court** ID: **0037507**

HSA No.: ? Own or Rent? (O or R) ____ Own or Rent Beginning: ____

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978? N

Cost Report Pd:		Licensed Beds:	120	Total Patient Days	33,812
Begin	**05/01/2002**	Licensed Bed Days:	43,800	% Occupied	77.20%
End	**04/30/2003**			Capital Days	40,734

1989 Property Tax COST: ____ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ____ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ____ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1992
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	5225889
2. Total licensed beds from cost report Page 2, Line 7, column 3	120
3. Line 1 divided by Line 2	$43,549
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	40,734
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	33,812
2. Total Licensed Bed Days * .93	40734
3. Capital Days (higher of Line 1 or Line 2)	40,734

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	91	2486860	226304260	12
2	2	0	0	0	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	91	99031	9011821	12
7	7	91	219089	19937099	12
8	8	91	205843	18731713	12
9	9	91	826676	75227516	12
10	10	91	91155	8295105	12
11	11	91	21960	1998360	12
12	12	91	3398	309218	12
13	13	92	22980	2114160	12
14	14	92	2000	184000	12
15	15	93	962	89466	12
16	16	93	13219	1229367	12
17	17	93	3750	348750	12
18	18	93	14525	1350825	12
19	19	94	6951	653394	12
20	20	95	1500	142500	12
21	21	96	3345	321120	12
22	22	96	4800	460800	12
23	23	97	3930	381210	12
24	24	97	12580	1220260	12
25	25	97	4165	404005	12
26	26	98	4340	425320	12
27	27	99	4475	443025	12
28	28	99	1819	180081	12
29	29	99	893	88407	12
30	30	99	938914	92952486	12
31	31	100	1365	136500	12
32	32	100	52250	5225000	12
33	33	100	1967	196700	12
34	34	102	19785	2018070	12A
35	35	102	19893	2029086	12A
36	36	101	1400	141400	12A
37	37	101	1125	113625	12A
38	38	103	5732	590396	12A
39	39	103	1855	191065	12A
40	40	103	4431	456393	12A
41	41	103	52902	5448906	12A
42	42	103	12149	1251347	12A
43	43	103	51875	5343125	12A
44	44	0	0	0	12A
45	45	0	0	0	12A
46	46	0	0	0	12A
47	47	0	0	0	12A
48	48	0	0	0	12A
49	49	0	0	0	12A
50	50	0	0	0	12A
51	51	0	0	0	12A
52	52	0	0	0	12A
53	53	0	0	0	12A
54	54	0	0	0	12A
55	55	0	0	0	12A
56	56	0	0	0	12A
57	57	0	0	0	12A
58	58	0	0	0	12A
59	59	0	0	0	12A
60	60	0	0	0	12A
61	61	0	0	0	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
73	73	0	0	0	12B
74	74	0	0	0	12B
75	75	0	0	0	12B
76	76	0	0	0	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

485945881 5225889 92.98817503

Base Year = 1992

TABLE 1 error

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	254,875	11,155	3,990	270,020	0	270,020	0	270,020
2. Food Purchase	0	157,510	0	157,510	0	157,510	-4,330	153,180
3. Housekeeping	109,492	0	17,358	126,850	0	126,850	0	126,850
4. Laundry	33,102	10,515	0	43,617	0	43,617	0	43,617
5. Heat and Other Utilities	0	0	141,069	141,069	0	141,069	0	141,069
6. Maintenance	68,870	3,232	51,644	123,746	0	123,746	0	123,746
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	466,339	182,412	214,061	862,812	0	862,812	-4,330	858,482
9. Medical Director	0	0	42,300	42,300	0	42,300	0	42,300
10. Nursing & Medical Records	2,177,146	111,952	5,180	2,294,278	0	2,294,278	0	2,294,278
10a. Therapy	319,093	1,731	0	320,824	0	320,824	0	320,824
11. Activities	62,448	2,850	2,364	67,662	0	67,662	1,335	68,997
12. Social Services	28,179	0	0	28,179	0	28,179	0	28,179
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,586,866	116,533	49,844	2,753,243	0	2,753,243	1,335	2,754,578
17. Administrative	78,208	0	229,485	307,693	0	307,693	-229,485	78,208
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	46,535	46,535	0	46,535	-3,955	42,580
20. Fees, Subscriptions & Promotion	0	0	25,875	25,875	0	25,875	0	25,875
21. Clerical & General Office	303,203	7,707	82,018	392,928	0	392,928	213,066	605,994
22. Employee Benefits & Payroll	0	0	728,761	728,761	0	728,761	0	728,761
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	21,188	21,188	0	21,188	0	21,188
25. Other Admin. Staff Trans	0	0	561	561	0	561	0	561
26. Insurance-Prop.Liab.Malpractice	0	0	85,333	85,333	0	85,333	0	85,333
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	381,411	7,707	1,219,756	1,608,874	0	1,608,874	-20,374	1,588,500
29. Total General Administrative	3,434,616	306,652	1,483,661	5,224,929	0	5,224,929	-23,369	5,201,560
30. Depreciation	0	0	222,745	222,745	0	222,745	13,488	236,233
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	233,285	233,285	0	233,285	-7,635	225,650
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	9,631	9,631	0	9,631	0	9,631
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	465,661	465,661	0	465,661	5,853	471,514
38. Medically Necessary T	0	0	4,229	4,229	0	4,229	0	4,229
39. Ancillary Service Cent	0	614,194	0	614,194	0	614,194	0	614,194
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	61,320	61,320	0	61,320	0	61,320
43. Other (specify):*	0	0	119,844	119,844	0	119,844	-119,844	0
44. Total Special Cost Ce	0	614,194	185,393	799,587	0	799,587	-119,844	679,743
45. Grand Total	3,434,616	920,846	2,134,715	6,490,177	0	6,490,177	-137,360	6,352,817

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	632,979	632,979
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,163,272	1,163,272
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	70,134	70,134
7. Other Prepaid Expenses	3,160	3,160
8. Accounts Receivable-Owner/Related Party	86,437	86,437
9. Other (specify):	0	0
10. Total current assets	1,955,982	1,955,982
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	504,179	504,179
14. Buildings, at Historical Cost	5,212,124	5,225,889
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,191,298	1,190,428
17. Accumulated Depreciation (book methods)	-2,858,139	-2,861,385
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	66,660	66,660
24. Total Long-Term Assets	4,116,122	4,125,771
25. Total Assets	6,072,104	6,081,753
CURRENT LIABILITIES		
26. Accounts Payable	148,826	148,826
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	84,750	84,750
30. Accrued Salaries Payable	284,366	284,366
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	56,462	56,462
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,674,266	2,674,266
37. Other Current Liabilities (specify):	257,540	257,540
38. Total Current Liabilities	3,506,210	3,506,210
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	4,208,083	4,208,083
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	4,208,083	4,208,083
46.Total Liabilities	7,714,293	7,714,293
47.Total Equity	-1,642,189	-1,632,540
48.Total Liabilities and Equity	6,072,104	6,081,753

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	6,005,654
2. Discounts and Allowances for all Levels	-1,570,959
Subtotal - Inpatient Care	4,434,695
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,018,804
7. Oxygen	75,003
Subtotal - Anciliary Revenue	1,093,807
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	3,337
14. Non-Patient Meals	3,356
15. Telephone, Television, and Radio	5,640
16. Rental of Facility Space	0
17. Sale of Drugs	799,678
18. Sale of Supplies to Non-Patients	0
19. Laboratory	15,436
20. Radiologyand X-Ray	0
21. Other Medical Services	189,129
22. Laundry	0
Subtotal - Other Operating Revenue	1,016,576
24. Contributions	0
25. Interest and Other Investments Income	7,635
Subtotal - Non-Operating Revenue	7,635
27. Other Revenue (specify):	545
28. Other Revenue (specify):	5,150
Subtotal - Other Revenue	5,695
30. Total Revenue	6,558,408
31. General Services	862,812
32. Health Care	2,753,243
33. General Administration	1,608,874
34. Ownership	465,661
35. Special Cost Centers	738,267
35. Provider Participation Fee	61,320
37. Other	0
40. Total Expenses	6,490,177
41. Income Before Income Taxes	68,231
42. Income Taxes	0
43. Net Income or Loss for the Year	68,231